Testimony of

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Chairman, Congressman Chris Smith,
Ranking Member, Congressman Donald Payne

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Chairman Smith, Congressman Payne, thank you for inviting me to testify on behalf of the Roll Back Malaria partnership and the hundreds of millions of people around the world who are threatened each day by the scourge of malaria. I commend this committee and the U.S. Congress for its strong leadership in the fight against malaria and other global pandemics such as tuberculosis and AIDS.

I would also like to take a moment to express my gratitude to Dr. Dybul and the other esteemed witnesses at this hearing for their important efforts in this fight. Millions of lives will be saved in Africa and around the world thanks to their work and that of their colleagues both here in Washington and in affected countries.

The Intolerable Toll on Africa

I speak before you today as not only a representative of the Roll Back Malaria Partnership and UNICEF, but also as an African citizen who has witnessed and endured the devastating impact of the malaria. I come from Senegal, a small West African country of 10 million people roughly the size of the state of South Dakota. Each year, more than one million people in Senegal experience the shaking chills, fevers and sweats of malaria.[1] Some are incapacitated for days or weeks, losing valuable time at work or school. Others, mostly children under the age of five, are not so fortunate. Thousands of Senegalese children die of malaria and its effects each year. The children that do survive a bout of malaria are often left with anemia, neurological damage, or other disorders which threaten their health and development.

Sadly, Senegal's story is not unique. Countries throughout sub-Saharan Africa bear a similar, and often greater, burden of malaria. Nearly one million Africans die from and more than 300 million are debilitated by malaria each year.[2] Hospitals and clinics throughout the continent are flooded by people seeking treatment and care for severe malaria episodes. In some areas, half of all hospital admissions are due to malaria alone. The disease is not only taking a terrible human toll, but is also crippling the economic potential of the continent. Factories and farms operate below capacity because workers are frequently incapacitated by malarial illness. Classrooms are filled with the empty chairs of children who lie at home shaking and sweating. Economists conservatively estimate that malaria costs Africa $12 billion – 1.3 percent of its aggregate gross domestic product – in lost productivity each year.[3]

An Effective Arsenal

For decades, we had a simple weapon we could use to fight back against this killer, a drug called chloroquine. It was cheap, safe, and effective, curing a child in three days for just ten cents, and countless lives were saved. However, the medicine never reached everyone who needed it. On average, less than half of infected African children received any form of

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[1] World Health Oranization/UNICEF, *The Afria Malaria Report 2003,*(WHO/UNICEF, 2003, Geneva)
[2] Ibid.
[3] Gallup, John Luke and Sachs, Jeffrey D. "The Economic Burden of Malaria." The American Journal of Tropical Medicine and Hygiene, vol. 64, no. 1, 2, S (January-February 2001) pp. 85–96

treatment.[4] But recently, those who have taken chloroquine have found that it has had little or no effect. The deadliest malaria parasite, *plasmodium falciparum*, has adapted to resist the effects of chloroquine and other effective drugs. Over time, these drug-resistant parasites have spread so widely that today, a standard treatment will fail to cure 80 percent of malaria cases in some areas. Infection and death rates around the world have risen dramatically as a result.

Despite the loss of chloroquine, effective tools exist to prevent and treat malaria and more are on the horizon. All of these tools have two traits in common: they are cheap and they are effective.

The solution to the rise of drug-resistant malaria parasites is artemisinin-based combination therapies (ACTs), a group of medications formed from a Chinese plant which has been used to treat malaria fevers for centuries. These medications are not only highly effective, curing 98 percent of cases in three days, but they also prevent the development of drug-resistance by attacking the parasites from multiple directions. Unfortunately, though inexpensive by American standards, the $1.50 average cost of these medications is more than the daily income of most African families. As a result, many African countries were slow to change their treatment programs from the much cheaper chloroquine. However, in the last year, the Global Fund to Fight AIDS, Tuberculosis and Malaria has devoted new resources to underwrite these treatments, facilitating a massive shift to ACTs across Africa.

While treatment is essential, our first line of defense against malaria must be to prevent new infections by driving back its mode of transportation, A*nopheles* mosquitoes. There are several potent insecticides which can deter and destroy these tiny killers while causing no harm to humans. There are two principle methods of putting these insecticides into action: infusing them into the fibers of mosquito bed nets or spraying them on the walls of homes.

Bed nets have been available as malaria protection for centuries, but a recent innovation has greatly improved their effectiveness. Scientists have devised a way to integrate the insecticide into the synthetic fibers of the net so that it is released slowly over time. These new, long-lasting insecticide-treated bed nets (LLITNs, in the parlance of our times)cost just $5 and retain their full protective power for more than five years. When enough of these nets are deployed in a village, the mosquito population is decimated, and even those children who do not sleep under nets benefit from them. Scientific studies have found that when these nets are used by the majority of homes, mortality in children under the age of five from all causes – not just malaria – is reduced by roughly 20 percent.[5] Since malaria is only one of a number of major killers of young African children, this means nets can reduce child malaria deaths by as much 80 percent.

For decades, indoor residual spraying (IRS) with DDT was our primary weapon against mosquitoes. While there are now others, DDT remains the most effective option we have in

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[4] World Health Oranization/UNICEF, *The Afria Malaria Report 2003,*(WHO/UNICEF, 2003, Geneva)

[5] Lengeler Christian, Sharp Brian (2003) "Indoor residual spraying and insecticide-treated nets." In: *Reducing malaria's burden: evidence of effectiveness for decision makers,* (Global Health Council, 2003, Washington, D.C.). pp. 17–24. http://www.globalhealth.org/assets/publications/malaria.pdf

some situations and we must continue to use it. Spraying programs are sometimes dismissed as inefficient and costly because of the labor-intensive systems that are needed to roll them out. But programs in Mozambique, South Africa, and Zambia, among others, have drastically reduced malaria infections with relatively little cost, particularly in urban areas. In fact, studies have shown that IRS and LLITN programs are roughly equivalent in cost-effectiveness.[6]

All of these tools have a critical role to play in our efforts to control malaria, but this is not always acknowledged. Yesterday, I joined people across the world in recognizing Africa Malaria Day under the theme of "Unite Against Malaria." Even those of us who care passionately about the fight against malaria must work hard to achieve that simple goal. We must agree that LLITNs and IRS each have their place in our arsenal, chosen case by case, based on local conditions and the preferences of the country. We must agree that sometimes a bed must be provided for free and sometimes it must be sold for a small cost. And yes, we must agree that DDT is still needed to save thousands of lives.

By effectively implementing these tools, we can rapidly and dramatically drive down malaria infection rates across wide areas. A Global Fund-supported program in Lubombo Region of South Africa, Mozambique and Swaziland has reduced malaria prevalence by 90 percent through comprehensive insecticide spraying and delivery of ACT treatments.[7] Success stories such as these have led Professor Jeffrey Sachs and others to refer to malaria as the "quick win" in war against global poverty. It is not fantasy for us to imagine meeting the Millennium Development Goal of significantly reducing the global incidence of malaria by 2015.

New Hope on the Horizon

While the tools to eradicate malaria exist, the scientific community is working to create new ones. In the past three years, the Bill and Melinda Gates Foundation has channeled unprecedented resources into research for effective new malaria treatments and vaccines. The Medicines for Malaria Venture, a non-profit research foundation, has made great progress in synthesizing artemisinin, the key component of the highly effective ACT medications, which would dramatically cut the cost of these critical treatments. Last year, a successful trial by the Malaria Vaccine Initiative generated hope that an effective vaccine might be available in the next five years. It would not be a panacea, but even a partially-effective vaccine could save millions of lives.

As we work to scale-up the tools we already have, we must ensure that these important research efforts are not neglected. Even with the tremendous generosity of the Gates Foundation, more resources are needed to realize the full potential of these projects. I urge the world community, including the U.S. government, to support these needs.

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[6] Lengeler Christian, Sharp Brian (2003) "Indoor residual spraying and insecticide-treated nets." In: *Reducing malaria's burden: evidence of effectiveness for decision makers,* (Global Health Council, 2003, Washington, D.C.). pp. 17–24. http://www.globalhealth.org/assets/publications/malaria.pdf

[7] "Lubombo Region: Rolling Back Malaria in Southern Africa" (Friends of the Global Fight Against AIDS, Tuberculosis and Malaria, 2005, Washington, D.C.)

Critical Engines

These tools are only truly useful to us if we can deliver them to the people who need them most: tens of millions of the poorest and most vulnerable people living in the rural areas of Africa. It is a daunting task and there are many challenges — from the exodus of skilled health professionals, to weak national health budgets, to counter-productive taxes and tariffs on bed nets and others interventions. But these challenges have been overcome many times before. A recently published book by the Center for Global Development, Millions Saved: Proven Successes in Global Health, describes large-scale programs which successfully defeated diseases such as smallpox and river blindness in the face of similar obstacles.[8]

A host of partners, from small faith-based groups to bilateral development agencies, are working tirelessly to implement malaria control on a wide-scale in Africa. I wish to focus my remarks on two of these critical mechanisms, which have driven substantial new progress in the fight over the past three years: the Global Fund and the Roll Back Malaria Partnership.

The Global Fund to Fight AIDS, Tuberculosis and Malaria

The Global Fund to Fight AIDS, Tuberculosis, and Malaria, is a global partnership created three years ago to effectively raise and allocate massive new resources to fight these diseases. To date, it has committed more than $3.2 billion over two years to effective programs in 127 countries around the world. It has quickly become the largest single financier of malaria control, allocating nearly $1 billion over two years to 70 countries. The Global Fund's approach has ensured that its resources are helping all those who are engaged in the fight at the local level, including non-governmental and faith-based organizations, the private sector as well as national governments. Half of its resources are committed to non-governmental entities.

The Global Fund is the primary mechanism for U.S. efforts to fight malaria and tuberculosis worldwide. In FY2005, 61 percent of U.S. funding to fight malaria and 42 percent of funding to fight tuberculosis was channeled through the Global Fund.[9] The U.S. is the Fund's largest single donor, contributing more than $1 billion to the Fund to date. Roughly $450 million of this amount is being used to fight malaria and TB. The Global Fund also works closely with Ambassador Tobias to coordinate efforts to fight the AIDS pandemic.

Global Fund resources have already had a significant impact. By the end of 2004, its malaria programs had distributed nearly 1.4 million ITNS and provided 300,000 ACT treatments. Its results on TB and AIDS were similarly robust, with nearly 400,000 people treated for TB and 130,000 people receiving life-prolonging AIDS treatment. And its portfolio is still young. Within the next five years, its current malaria programs plan to distribute 108 million bed nets and more than 145 million ACT treatments.

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[8] Levine, Ruth Millions Saved: Proven Successes in Global Health Center for Global Development, Washington, D.C; November, 2004.

[9] Foreign Operations, Export Financing, and Related Programs Appropriations Act, 2005

The Global Fund's impact can already be seen at the country level. In the Lubombo Region of Southern Africa, it has built upon a successful program launched by a group of more than 100 private companies, which recognized the economic benefits of controlling malaria in the area. Global Fund resources have enabled the program, which has reduced malaria prevalence by 90 percent across large areas of the region, to expand its activities to more than 40,000 square miles. In Zambia, the Churches Health Association of Zambia has used Global Fund money to purchase and distribute nearly 35,000 ACTs and 18,000 bed nets through more than 250 local faith-based organizations.[10]

This morning, I joined leaders from the U.S. Congress and international organizations to announce one of the Global Fund's latest accomplishments. Last spring, the Global Fund responded to critiques from the academic community and U.S. Congress that it was funding outdated and ineffective malaria treatments such as chloroquine by undertaking a massive review and reprogramming of its malaria treatment grants. With the help of the Roll Back Malaria Partnership and other partners, the Global Fund switched its grants in 19 countries to the more effective ACTs. This process has begun to show success. The Global Fund will sign grants that will enable seven African countries to purchase more than 100 million ACT treatments over the next two years. Other grants in its malaria portfolio will purchase at least 100 million more. This is one of the most rapid expansions of a drug treatment in the history of global public heath – only 10,000 ACTs were used in sub-Saharan Africa two years ago.

The Roll Back Malaria Partnership

The Global Fund is the war chest in the fight against malaria, providing much of the financing needed to scale-up control programs. But it cannot win this fight alone. Countries need help in choosing which tools to use and ensuring they are purchased and distributed swiftly and effectively. This is the function of the Roll Back Malaria Partnership (RBM). Established in 1998, RBM brings together major partners, including donor and endemic country governments, multilateral agencies, private corporations and foundations, NGOs, and academic institutions, to steer the fight against malaria through increased coordination and key policy decisions. At its founding, the partnership set the goal of halving the burden of malaria worldwide by 2010.

RBM has a corps of key staff who help enact the policies and implement the goals of the Parnership's Board. Under the strong leadership of Dr. Awa Marie Coll-Seck, the RBM Secretariat has played an important role in ensuring countries have access to the tools they need. Last year, it facilitated the transfer of LLITN technology from the Sumitomo Chemical Company in Japan to the AtoZ Corporation in Tanzania. This has significantly increased the global production of LLITNS and dramatically reduced the shipping costs to African countries. Together with the Global Fund and other partners, RBM also helped 19 countries switch their national treatment policies to ACTs.

RBM Secretariat staff has also helped countries clear obstacles that have hindered the implementation of large-scale malaria control programs. In Tanzania, for example, an ambitious, Global Fund-sponsored plan to distribute bed nets through a voucher scheme

[10] "The Churches Health Association of Zambia" (Friends of the Global Fight Against AIDS, Tuberculosis and Malaria, 2005, Wahington D.C. www.theglobalfight.org)

linked to antenatal clinics was faltering because of inefficient structures. RBM convened experts to help the CCM revise the work plan and accelerate scale-up of the program. As a result, nearly half of the country now has access to the voucher scheme. In Malawi, RBM brought together the major local and international partners to reach consensus on the best strategies for distributing bed nets. This has contributed to a growth in national ITN coverage from 12 percent to 58 percent in just two years. In these and other countries, RBM is ensuring that U.S. taxpayer money, through the Global Fund and other mechanisms, is having the maximum impact on the lives of people affected by malaria.

More Resources Now Needed to Achieve "Quick Wins"

The Global Fund and RBM Secretariat need more resources to sustain and expand their important work.

With the help of U.S. financial support, the Global Fund has launched more than 300 programs, which have already impacted the lives of millions of people threatened by malaria, tuberculosis and AIDS. Many of these programs are approaching the end of their initial two-year grants and require additional funding to continue their work for the full five-year program term.

In 2006, the Global Fund requires $2.4 billion just to renew these existing successful grants. In addition, the Global Fund's Board has also launched a new round of grants to ensure that its efforts keep pace with the constantly growing devastation of the three diseases. It estimates that it will need $1 billion to approve a robust round of new grants.

I urge the Congress to meet one-third of this total need, **$1.1 billion,** in the FY2006 budget process to ensure that the Global Fund is not forced to terminate effective life-saving programs

The RBM Partnership Secretariat urgently needs additional resources. This year, it requires $3.6 million just to continue its operations at the current level and more than $15 million to fulfill the objectives identified by the partners on its Board. The U.S. has already contributed $700,000 this year through the US Agency for International Development, but more is desperately required.

I urge the Congress to contribute at least **$1.2 million** more (one-third of the immediate shortfall) and to call upon another other donor country governments in Europe and around the world to match that commitment.